DEPARTMENT OF PUBLIC HEALTH
AND HUMAN SERVICES

CHAPTER 90

MENTAL HEALTH MEDICAID FUNDED
1115 AND 1915 WAIVERS

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Home and Community-based Services Waiver for
Adults with Severe Disabling Mental Illness

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Subchapter 4

Home and Community-based Services Waiver for Adults with Severe Disabling Mental Illness

37.90.401 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: FEDERAL AUTHORIZATION AND STATE ADMINISTRATION (1) The department has submitted a proposal seeking approval from the U.S. Department of Health and Human Services (HHS), under 42 CFS 441.300 through 441.310, to establish a program of Medicaid funded home and community-based services for persons who have severe disabling mental illness, as defined in ARM 37.89.103, and who would otherwise have to reside in and receive Medicaid reimbursed care in a nursing facility or a hospital. Upon formal approval, the department will initiate the program in accordance with the conditions of approval governing federal and state authorities and these rules.

(2) The department, in accordance with the state and federal statutes and the rules generally governing the provision of Medicaid funded home and community-based services, any federal-state agreements specifically governing the provision of the Medicaid funded home and community-based services to be delivered under this program, and within the available funding appropriated for the program, may determine within its discretion:

(a) the types of services to be available through the program;

(b) the amount, scope, and duration of the services available through the program;

(c) the categories of persons to be served through the program;

(d) the total number of persons who may receive services through the program;

(e) the total number of persons who may receive services through the program by category of eligibility, geographical area, or specific case management team; and

(f) eligibility of individual persons for the program.

(3) Enrollment in the program and the provision of services through the program are at the discretion of the department. There is no legal entitlement to enroll in the program or to receive any or all the services available through the program.

(4) The state has received federal approval to waive statewide coverage in the provision of program services. Program services may only be delivered to recipients in the following service areas for which federal approval of coverage has been received:

(a) Yellowstone County Region, inclusive of the counties of Yellowstone, Big Horn, Carbon, Stillwater, and Sweet Grass;

(b) Cascade County Region, inclusive of the counties of Cascade, Blaine, Chouteau, Glacier, Hill, Liberty, Pondera, Teton, and Toole; and

(c) Butte-Silver Bow County Region, inclusive of the counties of Butte-Silver Bow, Beaverhead, Deer Lodge, Granite, and Powell. (History: 53-2-201, 53-6-402, MCA; IMP, 53-2-401, 53-6-402, MCA; NEW, 2006 MAR p. 2665, Eff. 10/27/06.)

37.90.402 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: THE PROVISION OF SERVICES

(1) The services available through the program are limited to those specified in this rule.

(2) The department may determine the particular services of the program to make available to a recipient based on, but not limited to, the following criteria:

(a) the recipient's need for a service generally and specifically;

(b) the availability of a specific service through the program and any ancillary service necessary to meet the recipient's needs;

(c) the availability otherwise of alternative public and private resources and services to meet the recipient's need for the service;

(d) the recipient's risk of significant harm or of death if not in receipt of the service;

(e) the likelihood of placement into a more restrictive setting if not in receipt of the service; and

(f) the financial costs for and other impacts on the program arising out of the delivery of the service to the person.

(3) A person enrolled in the program may be denied a particular service available through the program that the person desires to receive or is currently receiving.

(4) Bases for denying a service to a person include, but are not limited to:

(a) the person requires more supervision than the service can provide;

(b) the person’s needs, inclusive of health, cannot be effectively or appropriately met by the service;

(c) access to the service, even with reasonable accommodation, is precluded by the person’s health or other circumstances;

(d) a necessary ancillary service is no longer available; or

(e) the financial costs for and other impacts on the program arising out of the delivery of the service to the person.

(5) The following services, as defined in these rules, may be provided through the program:

(a) case management services;
(b) homemaking;
(c) personal assistance;
(d) adult day health;
(e) habilitation;
(f) respite care;
(g) personal emergency response systems;
(h) nutrition services;
(i) nonmedical transportation;
(j) outpatient occupational therapy;
(k) nursing;
(l) psycho-social consultation;
(m) dietetic services;
(n) adult residential care;
(o) specially trained attendant care;
(p) chemical dependency counseling;
(q) specialized medical equipment and supplies;
(r) supported living;
(s) illness management and recovery services; and
(t) Wellness Recovery Action Plan (WRAP) services.

(6) Monies available through the program may not be expended on the following:

(a) room and board; and
(b) special education and related services as defined at 20 USC 1401(16) and (17).

(7) A program service is not available to a recipient if that type of service is otherwise available to the recipient from another source. (History: 53-2-201, 53-6-402, MCA; IMP, 53-2-401, 53-6-402, MCA; NEW, 2006 MAR p. 2665, Eff. 10/27/06.)

Rules 37.90.403 through 37.90.405 reserved

37.90.406 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: PROVIDER REQUIREMENTS

(1) Services of the program may only be provided by or through a provider that:

(a) is enrolled with the department as a Medicaid provider or, if not an enrolled Medicaid provider, is under contract with a Medicaid provider that the department is contracting with for home and community-based case management services and that the department has authorized to reimburse non-Medicaid providers;

(b) meets all the requirements necessary for the receipt of Medicaid monies;

(c) has been determined by the department to be qualified to provide services to adults with severe disabling mental illness;

(d) is a legal entity;

(e) is appropriately insured as determined by the department; and

(f) meets all facility and other licensing requirements applicable to the services offered, the service settings provided, and the professionals employed.

(2) A recipient's immediate family members may not provide services to the recipient as a reimbursed provider or as an employee of a reimbursed provider. Immediate family members include a spouse or legal guardian.

(3) A provider may also provide support to other family members in the recipient's household during hours of program reimbursed service if approved by the case management team. (History: 53-2-201, 53-6-402, MCA; IMP, 53-2-401, 53-6-402, MCA; NEW, 2006 MAR p. 2665, Eff. 10/27/06.)

Rule 37.90.407 reserved

37.90.408 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: REIMBURSEMENT (1) Services available through the program are reimbursed as provided in this rule.

(2) The following services are reimbursed as provided in (3):

(a) homemaking;

(b) adult day health;

(c) habilitation;

(d) personal emergency response systems;

(e) nutrition;

(f) psycho-social consultation;

(g) nursing;

(h) dietetic services;

(i) specially trained attendant care;

(j) chemical dependency counseling;

(k) supported living;

(l) adult residential care;

(m) respite care not provided by a nursing facility;

(n) nonmedical transportation;

(o) specialized medical equipment and supplies;

(p) illness management and recovery services; and

(q) Wellness Recovery Action Plan (WRAP).

(3) The services specified in (2) are, except as otherwise provided in (4), reimbursed at the lower of the following:

(a) the provider's usual and customary charge for the service; or

(b) the rate negotiated with the provider by the case management team up to the department's maximum allowable fee.

(4) The services specified in (2) are reimbursed as provided in (3) except that reimbursement for components of those services that are incorporated by specific cross reference from the general Medicaid program may only be reimbursed in accordance with the reimbursement methodology applicable to the component service of the general Medicaid program.

(5) The following services are reimbursed in accordance with the referenced provisions governing reimbursement of those services through the general Medicaid program:

(a) personal assistance as provided at ARM 37.40.1105; and

(b) outpatient occupational therapy as provided at ARM 37.86.610.

(6) Case management services are reimbursed, as established by contractual terms, on either a per diem or hourly rate.

(7) Respite care services provided by a nursing facility are reimbursed at the rate established for the facility in accordance with ARM Title 37, chapter 40, subchapter 3.

(8) Reimbursement will not be paid for a service that is otherwise available from another source.

(9) No copayment is imposed on services provided through the program but recipients are responsible for copayment on other services reimbursed with Medicaid monies.

(10) Reimbursement is not available for the provision of services to other members of a recipient's household or family unless specifically provided for in these rules. (History: 53-2-201, 53-6-402, MCA; IMP, 53-2-401, 53-6-402, MCA; NEW, 2006 MAR p. 2665, Eff. 10/27/06.)

Rule 37.90.409 reserved

37.90.410 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: ELIGIBILITY AND SELECTION

(1) The department may consider for eligibility in and may enroll in the program persons who the department determines qualify for enrollment in accordance with the criteria in ARM 37.90.410.

(2) In order to be considered by the department for eligibility in the program, a person must be determined to qualify for enrollment in accordance with the criteria in this rule.

(3) A person is qualified to be considered for enrollment in the program if the person meets the following criteria:

(a) is at least 18 years of age and, if under the age of 65, has been determined to be disabled according to the Social Security Administration;

(b) is Medicaid eligible;

(c) requires the level of care of a nursing facility as determined in accordance with the preadmission screening provided for in ARM 37.40.202, 37.40.205, and 37.40.206;

(d) does not currently reside in a hospital or a nursing facility;

(e) has needs that can be met through the program;

(f) meets the severe disabling mental illness definition at ARM 37.89.103; and

(g) resides in one of the following service areas for which federal approval of coverage has been received:

(i) Yellowstone County Region, inclusive of the counties of Yellowstone, Big Horn, Carbon, Stillwater, and Sweet Grass;

(ii) Cascade County Region, inclusive of the counties of Cascade, Blaine, Chouteau, Glacier, Hill, Liberty, Pondera, Teton, and Toole; and

(iii) Butte-Silver Bow County Region, inclusive of the counties of Butte-Silver Bow, Beaverhead, Deer Lodge, Granite, and Powell.

(4) The department may consider for an available opening for program services a person who, as determined by the department:

(a) meets the criteria of ARM 37.90.410;

(b) is actively seeking services;

(c) is in need of the services available;

(d) is likely to benefit from the available services; and

(e) has a projected total cost of plan of care that is within the limits specified in ARM 37.90.413.

(5) The department offers an available opening for program services to the applicant, as determined by the department, who is:

(a) most in need of the available services;

(b) most likely to benefit from the available services; and

(c) whose projected total cost plan of care is within the applicable limits specified in ARM 37.90.413.

(6) Factors to be considered in the determination of whether a person is:

(a) in need of the available program services;

(b) likely to benefit from those services; and

(c) which person is most likely to benefit from the available services include, but are not limited to, the following:

(i) medical condition;

(ii) degree of independent mobility;

(iii) ability to be alone for extended periods of time;

(iv) presence of problems with judgment;

(v) presence of a cognitive impairment;

(vi) prior enrollment in the program;

(vii) current institutionalization or risk of institutionalization;

(viii) risk of physical or mental deterioration or death;

(ix) willingness to live alone;

(x) adequacy of housing;

(xi) need for adaptive aids;

(xii) need for 24 hour supervision;

(xiii) need of person's caregiver for relief;

(xiv) appropriateness for the person, given the person's current needs and risks, of services available through the program;

(xv) status of current services being purchased otherwise for the person; and

(xvi) status of support from family, friends, and community.

(7) A recipient may be removed from the program by the department. Bases for removal from the program include, but are not limited to the following:

(a) a determination by the case management team that the services, as provided for in the plan of care, are no longer appropriate or effective in relation to the person's needs;

(b) the failure of the person to use the services as provided for in the plan of care;

(c) the behaviors of the person place the person, the person's caregivers, or others at serious risk of harm or substantially impede the delivery of services as provided for in the plan of care;

(d) the health of the person is deteriorating or in some other manner placing the person at serious risk of harm;

(e) a determination by the case management team that the service providers necessary for the delivery of services to the person, as provided for in the plan of care, are unavailable;

(f) a determination that the total cost of the person's plan of care is not within the limits specified at ARM 37.90.413;

(g) the person no longer requires the level of care of a nursing facility as determined in accordance with the preadmission screening provided for in ARM 37.40.202, 37.40.205, and 37.40.206; and

(h) the person no longer resides in one of the counties specified in ARM 37.90.410. (History: 53-2-201, 53-6-402, MCA; IMP, 53-2-401, 53-6-402, MCA; NEW, 2006 MAR p. 2665, Eff. 10/27/06.)

Rule 37.90.411 reserved

37.90.412 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: PLANS OF CARE (1) A plan of care is a written plan of supports and interventions, inclusive of personal recovery oriented goals to guide the provision of services, based on an assessment of the status and needs of a recipient. The plan of care describes the needs of the recipient and the services available through the program and otherwise that are to be made available to the recipient in order to maintain the recipient at home and in the community.

(2) The services that a recipient may receive through the program and the amount, scope, and duration of those services must be specifically authorized in writing through an individual plan of care for the person.

(3) The plan of care is initially developed upon the person's entry into the program. The plan must be reviewed and, if necessary, revised at intervals of at least six months beginning with the date of the initial plan of care.

(4) Each plan of care is developed, reviewed, and revised by the case management team.

(5) The case management team, in developing the plan of care, consults with the recipient or the recipient's legal representative, with treating and other appropriate health care professionals, and others who have knowledge of the recipient's needs.

(6) Each plan of care must include the following:

(a) diagnosis, symptoms, complaints, and complications indicating the need for services;

(b) a description of the recipient's functional level;

(c) objectives;

(d) any orders for:

(i) medication;

(ii) treatments;

(iii) restorative and rehabilitative services;

(iv) activities;

(v) therapies;

(vi) social services;

(vii) diet; and

(viii) other special procedures recommended for the health and safety of the recipient to meet the objectives of the plan of care;

(e) the specific program and other services to be provided, the frequency of the services, and the type of provider to provide them;

(f) the projected annualized costs of each program service; and

(g) names and signatures of all persons who have participated in developing the plan of care (including the recipient, unless the recipient's inability to participate is documented) which will verify participation, agreement with the plan of care, and acknowledgement of the confidential nature of the information presented and discussed.

(7) Inclusion of the need for and the identification of nonprogram services in the plan of care does not financially obligate the department to fund those services or to assure their delivery and quality.

(8) The case management team must provide a copy of the plan to the recipient.

(9) Plan of care approval is based on:

(a) completeness of plan;

(b) consistency of plan with the needs of the person; and

(c) feasibility of service provision, including cost-effectiveness of plan as provided for in ARM 37.90.413; and

(d) the conformance of the plan with ARM 37.90.401, 37.90.402, 37.90.406, 37.90.408, 37.90.410, 37.90.412, 37.90.413, 37.90.420, and 37.90.425.

(10) In accordance with ARM 37.85.414, the case management team must keep the plans of care on file and all records must be retained for a period of at least six years and three months from the date on which the service was rendered or until any dispute or litigation concerning the services is resolved, whichever is later.

(History: 53-2-201, 53-6-402, MCA; IMP, 53-2-401, 53-6-402, MCA; NEW, 2006 MAR p. 2665, Eff. 10/27/06.)

37.90.413 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: COST OF PLAN OF CARE (1) In order to maintain the program cost within the appropriate monies of the financial limitations imposed under federal authorities, the cost of plans of care for recipients may be limited by the department collectively and individually.

(2) The total annual cost of services for each recipient, except as provided in (3), may not exceed a maximum amount set by the department based on the number of recipients and the amount of monies available to the program as authorized in appropriation by the legislature.

(3) The total cost of services provided under a plan of care to a recipient may exceed the maximum amount set by the department if authorized by the department based on the department's determination that one or more of the following circumstances is applicable:

(a) the excess service need is short term and only a one time purchase is necessary;

(b) the excess service need is intensive services of 90 days or less which are necessary to:

(i) resolve a crisis situation which threatens the health and safety of the recipient;

(ii) stabilize the recipient following hospitalization or acute medical episode; or

(iii) prevent institutionalization during the absence of the normal caregiver;

(c) the excess service need is adult residential services; or

(d) the recipient has long term needs that result in the maximum amount being exceeded in minor amounts at various times.

(4) The cost of services to be provided under a plan of care is determined prior to implementation of the proposed plan of care and may be revised as necessary after implementation.

(5) The cost determination for the services provided under a plan of care may be made at any time that there is a significant revision in the plan of care. (History: 53-2-201, 53-6-402, MCA; IMP, 53-2-401, 53-6-402, MCA; NEW, 2006 MAR p. 2665, Eff. 10/27/06.)

Rules 37.90.414 through 37.90.419 reserved

37.90.420 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: NOTICE AND FAIR HEARING

(1) The department provides written notice to an applicant for and recipient of services when a determination is made by the department concerning:

(a) financial eligibility;

(b) level of care;

(c) feasibility, including cost-effectiveness of services to the recipient; and

(d) termination of recipient's eligibility for the program.

(2) The department provides a recipient of services with notice ten working days before termination of services due to a determination of ineligibility.

(3) A person aggrieved by any adverse final determinations as listed in (1)(a) through (d) or any adverse determinations regarding services in the plan of care may request a fair hearing as provided in ARM 37.5.304, 37.5.307, 37.5.313, 37.5.316, 37.5.318, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334, and 37.5.337.

(4) Fair hearings will be conducted as provided for in ARM 37.5.304, 37.5.307, 37.5.313, 37.5.316, 37.5.318, 37.5.322, 37.5.325, 37.5.328, 37.5.331, 37.5.334, and 37.5.337. (History: 53-2-201, 53-6-402, MCA; IMP, 53-2-401, 53-6-402, MCA; NEW, 2006 MAR p. 2665, Eff. 10/27/06.)

Rules 37.90.421 through 37.90.424 reserved

37.90.425 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: CASE MANAGEMENT, REQUIREMENTS (1) Case management is the planning for, arranging for, implementation of, and monitoring of the delivery of services available through the program to a recipient.

(2) Case management services include:

(a) developing a plan of care for a recipient;

(b) monitoring and managing a plan of care for a recipient;

(c) establishing relationships and contracting with service providers and community resources;

(d) maximizing a recipient's efficient use of services and community resources such as family members, church members, and friends;

(e) facilitating interaction among people working with a recipient;

(f) prior authorizing the provision of all services; and

(g) managing expenditures.

(3) A case management team must consist of:

(a) a registered nurse currently serving on a case management team serving persons who are recipients through the program of home and community services for the elderly and persons with physical disabilities; and

(b) a social worker currently employed by a licensed mental health center with two consecutive years experience providing case management services to adults with mental illness.

(4) The case management team must:

(a) be a legal entity contractually retained by the department to provide Medicaid funded home and community case management services to persons who are elderly or who have physical disabilities;

(b) function as directed by the department;

(c) assure that services provided to recipients are of appropriate quality and cost effective;

(d) provide case management services to no more than the number of persons specified by the department;

(e) manage expenditures within the allocated monies; and

(f) meet the department's reporting requirements. (History: 53-2-201, 53-6-402, MCA; IMP, 53-2-401, 53-6-402, MCA; NEW, 2006 MAR p. 2665, Eff. 10/27/06.)

Rules 37.90.426 and 37.90.427 reserved

37.90.428 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: ADULT RESIDENTIAL CARE, REQUIREMENTS (1) Adult residential care is the provision of supportive services to a recipient residing in an adult foster home, a residential hospice, or a personal care facility.

(2) Adult residential care may include:

(a) personal care services as specified at ARM 37.40.1101(1) through (5);

(b) homemaking as specified at ARM 37.90.437;

(c) social activities;

(d) recreational activities;

(e) medication oversight; and

(f) assistance in arranging transportation for medical care.

(3) Adult residential care must provide for 24 hour on site response staff to meet scheduled or unpredictable needs of recipients and to provide supervision of recipients for safety and security.

(4) A recipient of adult residential care may not receive the following services through the program:

(a) personal assistance as specified at ARM 37.90.431;

(b) homemaking services as specified at ARM 37.90.437;

(c) respite care as specified at ARM 37.90.438;

(d) medical alert personal emergency response system as specified at ARM 37.90.448; and

(e) nutrition as specified in ARM 37.90.446. (History: 53-2-201, 53-6-402, MCA; IMP, 53-2-401, 53-6-402, MCA; NEW, 2006 MAR p. 2665, Eff. 10/27/06.)

37.90.429 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: SUPPORTED LIVING, REQUIREMENTS (1) Supported living is the provision of supportive services to a recipient residing in an individual residence or in a group living situation.

(2) Supported living services may include:

(a) independent living evaluation;

(b) service coordination;

(c) 24 hour supervision of the person;

(d) health and safety supervision;

(e) homemaking services as specified at ARM 37.90.437;

(f) habilitation aide as specified at ARM 37.90.432;

(g) supported employment as specified at ARM 37.90.432;

(h) prevocational training as specified at ARM 37.90.432;

(i) nonmedical transportation as specified at ARM 37.90.450; and

(j) specially trained attendants as specified at ARM 37.90.436.

(3) An entity providing supported living services must have two years experience in providing services to persons with mental disabilities.

(4) This service must be prior authorized by the department. (History: 53-2-201, 53-6-402, MCA; IMP, 53-2-401, 53-6-402, MCA; NEW, 2006 MAR p. 2665, Eff. 10/27/06.)

37.90.430 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: ADULT DAY HEALTH, REQUIREMENTS (1) Adult day health is the provision of services to meet the health, social, and habilitation needs of a recipient in settings outside the recipient's place of residence. An entity providing adult day health services must be licensed as an adult day care center as provided at ARM 37.106.301, et seq. (History: 53-2-201, 53-6-402, MCA; IMP, 53-2-401, 53-6-402, MCA; NEW, 2006 MAR p. 2665, Eff. 10/27/06.)

37.90.431 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: PERSONAL ASSISTANCE, REQUIREMENTS (1) Personal assistance is the provision of an array of personal care and other services to a recipient for the purpose of meeting personal needs in the home and the community.

(2) Personal assistance services include the provision of the following services:

(a) personal care services as specified at ARM 37.40.1101(1) through (5) and 37.40.1301, 37.40.1302, 37.40.1305, 37.40.1306, 37.40.1307, and 37.40.1308;

(b) homemaking services as specified at ARM 37.90.436;

(c) supervision for health and safety reasons; and

(d) nonmedical transportation as specified at ARM 37.90.450.

(3) Personal assistance services do not include any skilled services that require professional medical training except as allowed in ARM 37.40.1301, 37.40.1302, 37.40.1305, 37.40.1306, 37.40.1307, and 37.40.1308.

(4) The requirements for the delivery of personal care services specified at ARM 37.40.1101, 37.40.1102, 37.40.1105, 37.40.1106, 37.40.1301, 37.40.1302, 37.40.1305, 37.40.1306, 37.40.1307, 37.40.1308, and 37.40.1315 govern the provision of personal assistance services. (History: 53-2-201, 53-6-402, MCA; IMP, 53-2-401, 53-6-402, MCA; NEW, 2006 MAR p. 2665, Eff. 10/27/06.)

37.90.432 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: HABILITATION, REQUIREMENTS

(1) Habilitation is the provision of intervention services designed for assisting a recipient to acquire, retain, and improve the self-help, socialization, and adaptive skills necessary to reside successfully at home and in the community.

(2) Habilitation services may include:

(a) residential habilitation;

(b) day habilitation;

(c) prevocational services;

(d) supported employment; and

(e) habilitation aide.

(3) Residential habilitation is habilitation provided in a community home for persons with mental disabilities.

(4) Day habilitation is habilitation provided in a day service setting.

(5) Prevocational services are habilitative activities that foster employability for a recipient who is not expected to join the general work force or participate in a transitional sheltered workshop within a year by preparing the recipient for paid or unpaid work. Prevocational services include teaching compliance, attendance, task completion, problem solving, and safety.

(6) Supported employment is intensive ongoing support to assist a recipient who is unlikely to obtain competitive employment in performing work activities in a variety of settings, particularly work sites where nondisabled persons are employed. Supported employment service includes supervision, training, and other activities needed to sustain paid work by a recipient.

(7) Habilitation aide is the assistance of an aide directed at fostering the recipient's ability to achieve independence in instrumental activities of daily living such as homemaking, personal hygiene, money management, transportation, housing, and use of community resources. Habilitation aide services include conducting an assessment and the provision of training and teaching.

(8) An entity, inclusive of its staff, providing habilitation services must be qualified generally to provide the services and specifically to meet each recipient's defined habilitation needs. (History: 53-2-201, 53-6-402, MCA; IMP, 53-2-401, 53-6-402, MCA; NEW, 2006 MAR p. 2665, Eff. 10/27/06.)

Rules 37.90.433 through 37.90.435 reserved

37.90.436 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: SPECIALLY TRAINED ATTENDANT CARE, REQUIREMENTS (1) Specially trained attendant care is the provision of supportive services to a recipient residing in their own residence.

(2) Specially trained attendant care services may include:

(a) personal assistance services as specified at ARM 37.90.431; and

(b) personal care services as specified at ARM 37.40.1101(1) through (5) and 37.40.1301, 37.40.1302, 37.40.1305, 37.40.1306, 37.40.1307, and 37.40.1308.

(3) A person providing specially trained attendant care must be an employee of a Medicaid enrolled personal assistance provider, trained in accordance with the department's training requirements by the provider and others to deliver the services that meet the specific needs of the recipient. (History: 53-2-201, 53-6-402, MCA; IMP, 53-2-401, 53-6-402, MCA; NEW, 2006 MAR p. 2665, Eff. 10/27/06.)

37.90.437 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: HOMEMAKING REQUIREMENTS

(1) Homemaking is the provision of general household activities or chore services to a recipient when the recipient is unable to manage the recipient's home or care for self or others in the home, or when another who is regularly responsible for these responsibilities is absent.

(2) Homemaking may include:

(a) household management services consisting of assistance with those activities necessary for maintaining and operating a home and may include assisting the recipient in finding and relocating into other housing;

(b) social restorative services consisting of assistance which further a recipient's involvement with activities and other persons; and

(c) teaching services consisting of activities which improve a recipient's or family's skills in household management and social functioning.

(3) Homemaking services do not include the provision of personal care as specified at ARM 37.40.1101 and 37.40.1302.

(4) A person providing homemaking services must be:

(a) physically and mentally able to perform the duties required; and

(b) literate and able to follow written orders. (History: 53-2-201, 53-6-402, MCA; IMP, 53-2-401, 53-6-402, MCA; NEW, 2006 MAR p. 2665, Eff. 10/27/06.)

37.90.438 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: RESPITE CARE, REQUIREMENTS (1) Respite care is the provision of supportive care to a recipient so as to relieve those unpaid persons normally caring for the recipient from that responsibility.

(2) Respite care services may be provided only on a short term basis, such as part of a day, weekends, or vacation periods.

(3) Respite care services may be provided in a recipient's place of residence or through placement in another private residence or other related community setting, a hospital, a nursing facility, or a therapeutic camp.

(4) A person providing respite care services must be:

(a) physically and mentally qualified to provide this service to the recipient; and

(b) aware of emergency assistance systems.

(5) A person who provides respite care services to a recipient may be required by the case management team to have the following when the recipient's needs so warrant:

(a) knowledge of the physical and mental conditions of the recipient;

(b) knowledge of common medications and related conditions of the recipient; and

(c) capability to administer basic first aid. (History: 53-2-201, 53-6-402, MCA; IMP, 53-2-401, 53-6-402, MCA; NEW, 2006 MAR p. 2665, Eff. 10/27/06.)

Rule 37.90.439 reserved

37.90.440 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: OUTPATIENT OCCUPATIONAL THERAPY, REQUIREMENTS (1) Outpatient occupational therapy services may include:

(a) occupational therapy services as specified in ARM 37.86.601; and

(b) services for habilitative or maintenance purposes.

(2) The requirements for the delivery of outpatient occupational therapy services provided at ARM 37.86.601, 37.86.605, 37.86.606, and 37.86.610 govern the provision of outpatient occupational therapy services.

(3) No visit limitation exists for maintenance therapy. (History: 53-2-201, 53-6-402, MCA; IMP, 53-2-401, 53-6-402, MCA; NEW, 2006 MAR p. 2665, Eff. 10/27/06.)

37.90.441 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: PSYCHO-SOCIAL CONSULTATION, REQUIREMENTS (1) Psycho-social consultation is consultation with providers and caregivers directly involved with a recipient and the development and monitoring of behavior programs.

(2) Psycho-social consultation services may include those services as specified at ARM 37.88.601 and 37.88.605.

(3) Requirements for the delivery of psychological services as specified at ARM 37.88.601 and 37.88.605 govern the provision of psycho-social consultation. (History: 53-2-201, 53-6-402, MCA; IMP, 53-2-401, 53-6-402, MCA; NEW, 2006 MAR p. 2665, Eff. 10/27/06.)

37.90.442 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: CHEMICAL DEPENDENCY COUNSELING, REQUIREMENTS (1) Chemical dependency counseling is the provision of counseling to a recipient with a substance abuse problem by a certified chemical dependency counselor.

(2) Chemical dependency counseling services may be provided on an individual or group basis. (History: 53-2-201, 53-6-402, MCA; IMP, 53-2-401, 53-6-402, MCA; NEW, 2006 MAR p. 2665, Eff. 10/27/06.)

Rules 37.90.443 and 37.90.444 reserved

37.90.445 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: DIETETIC SERVICES, REQUIREMENTS (1) Dietetic services are the management of a person's nutritional needs.

(2) Dietetic services may include evaluation and monitoring of nutritional status, nutrition counseling, dietetic therapy, dietetic education, and dietetic research necessary for the management of a recipient's nutritional needs.

(3) Dietetic services are limited to recipients whose disease or medical condition is caused by or complicated by diet or nutritional status. (History: 53-2-201, 53-6-402, MCA; IMP, 53-2-401, 53-6-402, MCA; NEW, 2006 MAR p. 2665, Eff. 10/27/06.)

37.90.446 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: NUTRITION, REQUIREMENTS

(1) Nutrition services are meals, congregate meals, and home delivered meals as specified at ARM 37.41.302 including the Meals on Wheels Program.

(2) The requirements for the delivery of nutrition services as specified at ARM 37.41.306 through 37.41.315 govern the provision of nutrition services.

(3) A full nutritional regimen of three meals a day may not be provided through this service. (History: 53-2-201, 53-6-402, MCA; IMP, 53-2-401, 53-6-402, MCA; NEW, 2006 MAR p. 2665, Eff. 10/27/06.)

37.90.447 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: NURSING, REQUIREMENTS

(1) Nursing is the provision of individual and continuous nursing care.

(History: 53-2-201, 53-6-402, MCA; IMP, 53-2-401, 53-6-402, MCA; NEW, 2006 MAR p. 2665, Eff. 10/27/06.)

37.90.448 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: PERSONAL EMERGENCY RESPONSE SYSTEMS, REQUIREMENTS (1) A personal emergency response system is an electronic device or mechanical system used to summon assistance in an emergency situation.

(2) A personal emergency response system must be connected to a local emergency response unit with the capacity to activate emergency medical personnel.

(3) The provision of a personal emergency response system as a service does not include the purchase, installation, or routine monthly charges of a telephone. (History: 53-2-201, 53-6-402, MCA; IMP, 53-2-401, 53-6-402, MCA; NEW, 2006 MAR p. 2665, Eff. 10/27/06.)

37.90.449 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: SPECIALIZED MEDICAL EQUIPMENT AND SUPPLIES, REQUIREMENTS (1) Specialized medical equipment and supplies is the provision of items of medical equipment and supplies to a recipient for the purpose of maintaining and improving the recipient's ability to reside at home and to function in the community.

(2) The provision of medical equipment and supplies services may include:

(a) the provision of consultation regarding the appropriateness of the equipment or supplies; and

(b) the provision of supplies and care necessary to maintain a service animal.

(3) Specialized medical equipment and supplies must:

(a) be functionally necessary and relate specifically to the recipient's disability;

(b) substantively meet the recipient's needs for accessibility, independence, health, or safety;

(c) be likely to improve the recipient's functional ability or the ability of a caregiver or service provider to maintain the recipient in the recipient's home; and

(d) be the most cost effective item that can meet the needs of the recipient.

(4) Any particular item of medical equipment or supplies, except for an item or supply necessary to maintain a service animal, is limited to a one time purchase unless otherwise authorized by the department in writing.

(5) Specialized medical equipment and supplies services do not include:

(a) items used for leisure and recreational purposes only;

(b) items of clothing;

(c) basic household furniture; or

(d) educational items including computers, software, and books unless such items are purchased in conjunction with an environmental control unit.

(6) A service animal is an animal trained to undertake particular tasks on behalf of a recipient that the recipient cannot perform and that are necessary to meet the recipient's needs for accessibility, independence, health, or safety.

(7) A service animal does not include any of the following:

(a) pets, companion animals, and social therapy animals;

(b) guard dogs, rescue dogs, sled dogs, tracking dogs, or any other animal not specifically designated as a service animal; or

(c) wild, exotic, or any other animals not specifically supplied by a training program on the approved provider list.

(8) Supplies necessary for the performance of a service animal may include, but are not limited to, leashes, harness, backpack, and mobility cart when the supplies are specifically related to the performance of the service animal to meet the specific needs of the recipient. Supplies do not include food to maintain the service animals.

(9) Care necessary to the health and maintenance of a service animal may include, but is not limited to, veterinarian care, transportation for veterinarian care, license, registration, and where the recipient or recipient's primary care giver is unable to perform it, grooming.

(10) Certain items of medical equipment or supplies for short term use, as specified by the department, may be leased or rented instead of purchased.

(11) The department may require a consultation prior to the purchase of certain equipment and supplies. (History: 53-2-201, 53-6-402, MCA; IMP, 53-2-401, 53-6-402, MCA; NEW, 2006 MAR p. 2665, Eff. 10/27/06.)

37.90.450 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: NONMEDICAL TRANSPORTATION, REQUIREMENTS (1) Nonmedical transportation is the provision to a recipient of transportation through common carrier or private vehicle for access to social or other nonmedical activities.

(2) Nonmedical transportation services are provided only after volunteer transportation services, or transportation services funded by other programs, have been exhausted.

(3) Nonmedical transportation providers must provide proof of:

(a) a valid Montana driver's license;

(b) adequate automobile insurance; and

(c) assurance of vehicle compliance with all applicable federal, state, and local laws and regulations.

(4) Nonmedical transportation services must be provided by the most cost effective mode.

(5) Nonmedical transportation services are available only for the transport of recipients to and from activities that are included in the individual plan of care. (History: 53-2-201, 53-6-402, MCA; IMP, 53-2-401, 53-6-402, MCA; NEW, 2006 MAR p. 2665, Eff. 10/27/06.)

Rules 37.90.451 through 37.90.459 reserved

37.90.460 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: ILLNESS MANAGEMENT AND RECOVERY SERVICES, REQUIREMENTS (1) Illness management and recovery program consists of a series of weekly sessions where licensed mental health practitioners provide services consisting of personalized strategies for managing mental illness and achieving personal goals to individuals who have experienced the symptoms of schizophrenia, bipolar disorder, and major depression.

(2) The services may be provided in an individual or group format and generally last between three to six months.

(3) Mental health practitioners work collaboratively with individuals by offering a variety of information, strategies, and skills for use to further their own recovery.

(4) Illness management and recovery has been identified as an evidence-based practice by the Substance Abuse and Mental Health Services Administration. (History: 53-2-201, 53-6-402, MCA; IMP, 53-2-401, 53-6-402, MCA; NEW, 2006 MAR p. 2665, Eff. 10/27/06.)

37.90.461 HOME AND COMMUNITY-BASED SERVICES FOR ADULTS WITH SEVERE DISABLING MENTAL ILLNESS: WELLNESS RECOVERY ACTION PLAN (WRAP) SERVICES, REQUIREMENTS (1) Wellness Recovery Action Plan (WRAP) is a self-management and recovery system.

(2) WRAP is designed to decrease and prevent intrusive or troubling feelings and behaviors, increase personal empowerment, improve quality of life, and assist individuals in achieving their own life goals.

(3) A person who provides WRAP services to a waiver participant will be required by the case management team to be certified by the Copeland Center. (History: 53-2-201, 53-6-402, MCA; IMP, 53-2-401, 53-6-402, MCA; NEW, 2006 MAR p. 2665, Eff. 10/27/06.)